EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

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THE CITY OF HUNTINGTON,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

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CABELL COUNTY COMMISSION,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

* *

Videotaped and videoconference deposition of GEORGE A. BARRETT taken by the Defendants under the Federal Rules of Civil Procedure in the above-entitled action, pursuant to notice, before Teresa S. Evans, a Registered Merit Reporter, all parties located remotely, on the 21st day of September, 2020.

past.

Q. Okay. And approximately how many remote depositions have you taken, or given?

A. More than ten.

Q. Okay. So nothing we'll do today I think will be new to you at least procedurally. Why don't we jump into it. Can you break down, again very roughly, the types of cases for which you've been retained by -- by type or category in the past?

A. Almost all of my testimony has been with regard to compensatory damages, as well as punitive damages. So I've certainly focused on damages, concepts, as an expert witness.

Those types of damages that I've calculated and testified have included loss of earnings and personal injury in wrongful death cases, loss of household services, the present value of future medical and care costs.

I've also worked on a number of commercial damages cases.

Q. In terms of the percentage of cases that you've been involved in, approximately what percent have been personal injury cases?

A. I really couldn't tell you that, because I don't track the cases by the status of the plaintiff whether it's a personal injury or a wrongful death.

Q. Do you keep a list of the cases in which you've testified by way of deposition or at trial?

A. Yes. In those cases where I've actually testified, yes, I maintain a list. I do not maintain a list of all the cases in which I've consulted and/or produced a written report.

Q. Did you produce a list of such cases in connection with your report in this matter?

A. I believe that a list of testimonies from the last four calendar years was produced.

Q. Okay. Would you say that more or less than half of the cases you've testified in in the past have been personal injury cases?

A. Again, it's difficult for me to quantify that, but certainly the vast majority of cases in which I've provided expertise as well as testified have been in personal injury and wrongful death matters.

Q. Okay. In wrongful death matters, what has your testimony generally comprised of?

A. The calculation of lost earnings, calculation of lost household services.

Q. And in the personal injury cases in which you've testified, what has your testimony consisted of?

A. Lost earnings, lost household services, as well as the present value of future medical and care costs.

Q. Now, you've used the term a couple times that was a three-word term that the first word was "lost" and the last word was "services" and I've not understood the word between there. Can you do that again for me?

A. Yes, household.

Q. Household.

A. Household services.

Q. Got it. Sorry. I think if we were in the same room, I would have caught it, but I think over the computer, I couldn't catch that. Okay.

You've written a fair amount of material relevant to your profession by way of, you know, professional publications. Is that right?

A. Yes, I have.

Q. And what have the subject matters,

model, correct?

A. I did, yes.

Q. And you prepared your own Excel spreadsheet that mirrors the categories in Doctor Alexander's redress model, correct?

A. Yes, I did.

Q. And what is the difference between your spreadsheet and Doctor Alexander's redress model spreadsheet?

A. Doctor Alexander's spreadsheet contains a lot of technical information that I'm not really qualified to discuss as it relates to his field of expertise, which I believe to be epidemiology.

But there is a category of information or several categories of information from his Excel spreadsheet that are relevant for my work, and very similar to what I would be looking at if it was a case in which we were talking about a personal injury and there was a life care plan involved; meaning that I still need to know those three pieces of information: What the thing that is going to be needed into the future, what that thing is, a good or a service; how frequently that thing is going to be needed; and how much does it cost.

Now, in this particular case, there was an additional piece of information that Doctor Alexander provides, and that is the number of people. Because unlike in a personal injury case, when we are assuming that just one individual is going to be requiring this, this is a large group of people that are needing these things in the future, so the numbers of people are important to me as well, because I have to have something to multiply with the base numbers before I project into the future.

As far as my report goes and what makes my report unique from Doctor Alexander's, is because -- is that I am looking at the base cost of each one of those items, multiplied by the number of people per Doctor Alexander, and Doctor Young as well, and then projecting the future value of that out through a 15-year time period based upon the proper inflationary measure, depending upon the category that that particular identified item would fall into.

Q. With respect to inputs received from either Doctor Alexander or Doctor Young concerning numbers of people, did you at any time question Doctor

Alexander or Doctor Young as to why they were deriving the number of people they had been -- they had derived?

A. No, I did not.

Q. Do you think it's the proper work of a forensic accountant such as yourself to question medical or population inputs that he or she receives?

A. As a matter of clarification, I am not an accountant; I'm an economist.

Q. Okay.

A. However, to answer your question, I do not believe that an accountant, nor an economist, would be qualified to review the expert opinions provided by a medical expert - in this case an epidemiologist; or in the case of Doctor Young, an expert social worker - as those individuals are experts in their field and economists and accountants are not.

Q. Mr. Barrett, you are also a vocational -- you have been in the past a vocational evaluator. Is that right?

A. Yes, that is correct.

Q. And can you describe what that is?

A. Yes. I am trained as a certified rehabilitation counselor. That certification and training -- and I have a master's degree in rehabilitation counseling from West Virginia University. That training is necessary for me to work with individuals who have experienced physical impairments that could perhaps result in work disabilities.

And the idea is that we work as counselors with individuals to try to get them back to work after the onset of injury. There's some exceptions to that, but generally, that's what we do as rehabilitation counselors. As a subspecialty within that particular field, I am a certified vocational evaluation specialist or a CVE.

So that additional credential specializes on the identification of transferable job skills that individuals may have. So if we have an individual who has been injured, I can evaluate that person's job skills and then utilize the medical information in the case to determine what types of jobs would be consistent with their residual functional abilities.

That information is then utilized in

the economic calculation of lost earnings to project what the lost earnings are in a model where post-injury earnings, those residual earnings the person can now earn, are subtracted from what they would have earned had they not been injured.

Q. And in this case, did you employ any of your knowledge or experience as a vocational evaluator?

A. I believe that I did, yes.

Q. Can you point me to where in your report you did?

A. Sure. Probably the easiest way to answer your question is to look at Appendix L of my report. And Appendix L is a table which lists the cost data sources which were utilized in my calculations, and there are three different individuals who provided those cost data.

You'll see in the second column, the first expert identified is myself, Barrett, and under that column are all of the specific items that I identify costs, because those particular cost items were based upon wage rates which would be paid to individuals who are working in the Huntington local labor market.

Now, just like we saw with the wage of the pharmacists, we have to increase into the future that $70.67. That's the starting point, again in 2019 dollars. Just like before, I'm going to use 3.49 percent to move from 2019 to 2020, and then we get $73.14.

Then I increase that by 3.44 percent - again the 30-year average of hourly wage growth in the United States - and we get $75.66 per hour. So when you look at Tab 1A2, in the Year 2021, the hourly rate, weighted proportionately to employment within the occupations, is $75.66 - that's the first column - multiplied by the total number of continuing education hours specified by Doctor Alexander, 5,015, and so the total in 2021, the total cost, is $379,425.

And we just simply do that math all the way across, using Doctor Alexander's population numbers, which here represent the continuing education hours, multiplied by the future value in each year of the weighted average for the median wages for these occupations, and then we get the grand total all the way across of $4,130,552.

Q. Now, currently, are doctors practicing in

the Cabell/Huntington area required to participate in continuing medical education programs?

A. I'm not a medical expert, so I -- I'm reluctant to answer the question as to what their continuing education requirements are. But what I can tell you is that Doctor Alexander specifically identified that the total number of hours for this abatement plan would be 5,015.

Whether or not those are above and beyond what the normal continuing education hours would be or not, I can't tell you.

Q. But you do understand from your prior work that doctors in West Virginia are required to participate in continuing medical education, right?

A. I have heard that they are required to fulfill CE requirements, yes.

Q. Okay. And do you know who mandates that doctors in West Virginia participate in continuing medical education? Is that the West Virginia Board of Medicine?

A. I don't know. I'm not an expert in that field, so I'm not comfortable in commenting or opining on the government agencies responsible for monitoring that.

Q. Do you have any reason to think that the City or County has anything to do with mandating continuing medical education for doctors?

A. Again, I don't have any opinions on the matter, because I've relied exclusively on Doctor Alexander's estimate that the beginning point is 5,015 hours per year.

Q. Do you have any certifications yourself, professional certifications, that require you to participate in continuing education programs?

A. Yes, I do.

Q. And do you ever get paid by anybody for attending those when you're not presenting but just when you're participating?

A. No, I do not.

Q. And do you know whether doctors in West Virginia are ever paid for satisfying their continuing medical education requirements by participating in courses?

A. Actually, I don't know the answer to that question.

Q. Do you know that currently the West Virginia Board of Medicine requires a three-hour Drug Diversion Training and Best Practice

Prescribing of Controlled Substances Training for all doctors in West Virginia?

A. No, I'm unfamiliar with that.

Q. And how, if at all, is the program that Doctor Alexander is contemplating different than the already-required three-hour program that the West Virginia Board of Medicine currently requires?

A. I'm actually uncertain as to how it differs, and I think that's probably a better question for Doctor Alexander.

Q. But, the way you analyze this, is you assume that doctors participating in this class - whatever it is - would be actually paid their customary wages for attending that class. Right?

A. Well, I think the idea is that there's an opportunity cost, so that if a medical provider is not at work and -- and working, and therefore billing their time and collecting for the services that they're providing, they're foregoing those wages, and instead, they are somewhere receiving training.

So it's a lost opportunity cost that's being valued by the weighted average hourly wage rate of those specific occupations.

Q. And who suffers that opportunity cost? The doctors? Or does the City and County somehow suffer?

A. I suppose it would depend upon who the employer is. The physicians will be missing out on the work opportunity, and the potential employer would be missing out on the employees who are going to be absent and at the training during that time period.

Q. Do you know whether doctors who engage in continuing medical education generally do that after work or during work?

A. I do not know when they perform their continuing education hours.

Q. Who are you employed by?

A. I am self-employed.

Q. Self-employed in a solo practice, or with others?

A. I have a business partner.

Q. But in a real world sense, you're assuming that -- not that doctors will be paid for attending, but that either they or their employer will suffer an opportunity cost loss because they engaged in this newly-mandated County-level

training as contemplated by the redress model. Correct?

A. I think that's the fear in the model, yes. If they're not at work because they're attending training, then they're missing out on wages, and that means that the clinics that they work for, the agencies that they work for, the firms that they work for are not recovering the revenue for the services that they're being provided during those time periods.

Q. And are you aware of any current or past mandatory continuing medical education requirement imposed by the City or the County as opposed to imposed by the West Virginia Board of Medicine?

A. I'm unfamiliar with the rules and regulations governing that aspect of the practice.

Q. In your profession, are there any county or city-level continuing education requirements?

A. In my work as a forensic economist and vocational evaluator?

Q. Right.

A. No, I cannot think of any.

Q. Okay. Can we turn to the next tab in your Appendix M, which is 1B, Patient And Public

Education.

A. Yes.

Q. Now, this tab costs out a mass media campaign that would somehow be, you know, anti-opioid use or addiction prevention. Is that right?

A. I'm actually unfamiliar with the content of what the mass media campaign would represent. I relied upon Doctor Alexander's estimate of what the cost and the coverage area would be for this particular item.

Q. And as a resident of West Virginia, have you ever seen either billboards or TV commercials that address the opioid abuse crisis?

A. I believe I have seen a billboard.

Q. Okay. And in terms of your pricing work in this case, did you make any effort to determine who funds such billboards in West Virginia and what those are costing?

A. No, I did not. I relied upon Doctor Alexander's opinions for this particular item.

Q. So what input, if any, did you supply to the analysis in this tab, as opposed to it being supplied by Doctor Alexander?

A. The growth rate. The growth rate that I utilized was based upon the Consumer Price Index less all medical categories of price inflation.

So the government, in keeping track of inflationary data, have an entire market basket - we call that the Consumer Price Index - and included in that are all types of items, including medical care.

There was an article that I read -- I don't recall the name of the article, but there was an article that I read that discussed the calculation of the future cost of mass media campaigns as it relates to substance abuse programs, and it was advised in that article that the Consumer Price Index less inflation -- less medical costs should be used.

So I've actually calculated that. You also have that as an Appendix in the main report, and the growth rate on average between 1990 and 2019 is 2.33 percent.

Q. In your conversations with County and City executives, did you ever ask any of them about any media campaigns they were currently running or had run in the past concerning opioid addiction?

A. No, I did not.

Q. As we sit here today, or during the course of your work, are you aware of any City or County-administered or funded media campaigns concerning opioid addiction?

A. No, I'm not.

Q. So I take it you don't know how much, if anything, the City or County have paid in the past to run or fund opioid addiction media campaigns; is that right?

A. I don't. And again, I think that may be an invalid way of looking at it, because the City has a finite amount of resources available.

So -- but the type of media campaign that is being considered by Doctor Alexander's redress model may not be what the City has ever done before, if the City has ever done anything before.

Q. Well, we talked earlier today about the mayor's Two-Year Plan and The City of Solutions plan. Did either of those discuss any media campaigns?

A. I don't recall the specifics on it.

Q. In your conversations with City and County

executives, has anyone ever told you that they thought that the current media campaigns were inadequate or needed to be expanded?

A. No. Again, that's outside the field of my expertise.

MR. HALLER: Okay. Why don't we take a short break, maybe come back a little bit after 11:30 or so? Does that make sense?

MR. BURNETT: Sure.

VIDEO OPERATOR: The time is 11:22, we're going off the record.

(A recess was taken after which the proceedings continued as follows:)

VIDEO OPERATOR: The time is 11:35, we are back on the record.

BY MR. HALLER:

Q. So Mr. Barrett, we were discussing Tab 1B of Appendix M, which is Patient and Public Education. That's Exhibits 3 and 3A. Do you recall that in Doctor Alexander's report, he talked about media campaigns that were funded by the federal CDC? That's like in Paragraphs 58, 59 and 60 of his report.

A. No, I don't recall that.

Q. Okay. Do you recall his -- that he discussed at least two media campaigns currently in -- you know, in the -- currently or in the past in the Cabell/Huntington community called Healthy Connections and Wake Up West Virginia?

A. No, I don't specifically recall that.

Q. Okay. Did you make any -- when you were doing your costing analyses, did you make any effort to determine the degree to which such media campaigns would be funded by the federal CDC?

A. No. I relied upon Doctor Alexander's input for this category.

Q. And did you make any effort to determine what portion, if any, of the Healthy Connections and Wake Up West Virginia campaigns currently in place were funded by the County or City as opposed to being funded by the federal CDC?

A. No, I did not.

Q. And do you know whether the media campaign you're pricing out here in this tab would meet and be -- meet CDC guidelines and be funded by the federal CDC?

A. No, that's beyond the field and scope of my expertise.

Q. Let's move to the next tab, which is the Tab 1C, Safe Storage and Drug Disposal. Again, we're still on Appendix M, Exhibits 3 and 3A.

A. Okay.

Q. Are you aware of any past or current safe disposal efforts in the Cabell/Huntington community?

A. No, I've relied upon Doctor Alexander for this item.

Q. And do you recall that in his report, he discussed, among other things, National Take-Back Day and some permanent collection sites at the Huntington and Milton Police Departments?

A. No, I don't recall those specific references from his report. I simply noted from his redress model what the per capita costs and the population numbers would be.

Q. And did you make any effort to determine the costs incurred by the County or City, if any, in connection with the existing collection sites at the Huntington and Milton Police Departments?

A. No, I did not. I -- again, I relied upon Doctor Alexander.

Q. You spoke to certain police department

Have you done any work looking at community that -- Communities that Care model to determine how programs implementing that model are funded?

A. No. And again, that would be beyond the scope of my expertise in this case. That particular issue, I believe, would be addressed by Doctor Alexander.

Q. You assume in your analysis that two community organizers would be hired. Who do you assume is going to hire those community organizers and pay them? Would they be employees of the County or the City, or would they be employees of some other organization and the County or City would fund their salaries?

A. This is a community organization, as it's been identified. I don't know if these would be government employees or if they would be private sector employees that are working for a nonprofit that is being coordinated or funded by a government agency or some other funding source, perhaps the defendants.

But -- it's just unclear as to who's actually going to be doing the work. Doctor

Alexander simply noted -- noted that the community organization will need to be staffed, and I have identified the costs necessary to staff the organization.

Q. And in your experience, are community organizers typically government employees, or are they typically employees of nonprofits?

A. Just in general, you know, I've seen both, actually.

Q. So tell me some examples of community organizers you're aware of that are government employees.

A. There are lots of community outreach programs which are part of municipal governments, county governments, state agencies that perform that type of service.

One is, at the State level, is the Women, Infants and Children's program which provides baby formula for mothers below a certain income threshold. That is a community organization, which is a government agency as well.

And privately, I mean, there are a number of nonprofit organizations that exist that promote certain special interests and goals within

a particular geography, so you know, I've seen both.

Q. And who provides funding for the winthrop program that you mentioned?

A. The WIC program? Is that what you're asking me?

Q. I thought you said winthrop. Maybe you said WIC --

A. No, it's the Women, Infants and Children, WIC.

Q. And who funds -- who provides the funding for that program?

A. The federal government through the U.S. Department of Agriculture.

Q. Are you aware of any prior instance where Cabell County or the City of Huntington have employed a community organizer?

A. I don't know that, no, I do not.

Q. Now, are you aware of any prior instance where the Cabell County or City of Huntington has paid the funding for a community organizer employed by a nonprofit?

A. I know that grants are issued by various government agencies, and that could include

municipalities as well as states as well as the federal government. And grants are primarily what nonprofits rely upon for their funding source.

Q. And are you aware of any grants provided by Cabell County or City of Huntington to any nonprofit?

A. Well, I wouldn't expect them to, because they probably lack the money necessary to do it.

But no, to answer your question, I'm unaware of any. But again, it's not surprising that they wouldn't exist because of the lack of funding.

Q. Why don't we go to the -- we can skip the next tab, which I think are your comparables, right?

A. Yes.

Q. And then the next tab, we can skip that which shows your trend rates for renting shelter, and then we can skip the next tab which relates to community organizer wages.

Well, actually, let's stick on that tab for a little bit, with regard to community organizer wages. You employ a 3.44 percent growth rate beginning in 2020. Where did you derive that

just like the previous, Doctor Alexander provided the number of opioid injection drug users reached by the syringe service program. He also provided with -- provided in the redress model the cost per client for the syringe service program.

Q. Did you make any effort to determine the cost of existing syringe service programs in the Cabell/Huntington community in connection with your work?

A. No. Again, Doctor Alexander provided this information, and I relied upon his opinion for these calculations.

Q. And with respect to existing syringe service programs, do you know who has provided the funding for those, whether it's come from the County or City or alternatively, from some Federal or State source?

A. No. But again, just like we've talked about with these other costs, even if such a program was being funded by another party, the intention from this particular redress model is to identify and effectively deal with the costs that have been created by the opioid epidemic.

So if some other funding mechanism or

some other agency was perhaps paying for this, typically we would not expect the defense to get a benefit from that just because they were lucky enough to have triggered an opioid epidemic in a geographic area which was providing a syringe program in the first place.

Q. Well, as far as you know, has the City or County ever funded, in whole or in part, a syringe service program using its own funds?

A. I believe that there was - and have been - some programs with regards to a syringe collection effort. I do recall that -- those types of programs and those types of costs have existed.

Q. So you are aware that -- of a syringe collection program taking place within the geographic boundaries of the City or County, but do you know who funded any such program?

A. No. Again, I'm not familiar with that, and I think that that would be irrelevant because it would -- it would be in violation of the collateral source rule as it relates to whether or not a defendant gets the benefit of a third party participating in and contributing toward the funding of one of -- any of these types of

programs.

Q. Well, under the collateral source rule, if somebody makes an expenditure that is later reimbursed, you're saying the defendant can't necessarily benefit from that. What I'm asking is: Has the County or City ever even in fact even made the expenditure, or are those programs just funded by others?

A. I'm not certain of that.

MR. BURNETT: I'll just make a general objection to the extent the question calls for a legal conclusion.

Q. In your annual growth cost growth rate in this category, what -- what comparable, you know -- how did you come up with this cost growth rate that you use here, and how does that compare with syringe service programs?

A. The future value growth rate inflationary category that I utilized is from the medical care commodities category for medical cost price inflation, and that includes medical equipment, essentially. So the types of costs that would be associated with this type of a program would be dealing with medical equipment because we're

talking about syringes and the collection points for syringes.

The rate of growth that I utilize for this over the long term, as you see here on this tab, is 3.16 percent annual growth.

If you look at the next page, you'll see that, again, the growth rates are specific for each year in the past. The cost per client is provided in Doctor Alexander's redress model at $774.30 in 2016 dollars, and then you'll see that I move from 2016 to 2017, I'm at 2.8 percent.

The next year, it's at 1.16. The year after that, the price actually decreases. The price index goes down by 0.04, and then the next year, it goes up by 3.12 percent.

So using a 30-year average again, a 1990 through 2019 average of the Medical Care Commodities Index, the average is 3.16 percent per year, and that's what I used to move those annual syringe service programs to a future value in each year.

Q. The next Tab 1E2a, is Drug Checking Machines. What does that reflect the cost of, a machine that does what?

treatment, right?

A. Yes, that is correct in the first year.

Q. Plus 41 people getting inpatient treatment. Right?

A. Yes, that is correct.

Q. All right. So I -- so let's see. So we've got 439 plus 452 plus forty -- oops. Sorry, I keep on hitting the wrong buttons here. That adds up to 3,152 people, right?

A. I did not do the math, so I will trust your number.

Q. Yea. You can trust 3,152 as the sum of 2,220, 439, 452 and 41. So if you go back to the bus trips, 359,021 bus trips divided by 3,152 people, we have 114 bus trips per person getting OUD. Does that sound about right?

A. I did not do the math that way. I looked at Doctor Alexander's redress model under Tab 2A and the seventh line identified in the first year, 2021, it states, "The total number of transportation vouchers needed per year, 359,021."

Q. And the Agency Profile shows 20 percent of the funding for the Transit Authority comes from federal assistance, right? At least for operating

funds.

A. 20.7 percent from federal assistance, according to this document.

Q. Right. And in terms of capital funds, federal assistance provides 77 percent of that funding. Right?

A. 76.9 percent.

Q. So if the system needed to buy new buses, would you assume that's capital funds or operating funds?

A. Capital funds, I would assume.

Q. So in doing your calculations, did you make any effort to determine if new buses or additional buses were needed to make these trips, did you take into account the fact that 77 percent of that funding for those new buses would come from federal assistance?

A. No, because again, as we've discussed previously regarding the other categories, it's a collateral source. I mean, just because the federal government is there and providing funding sources doesn't mean that the burden is placed upon the federal government for the opioid epidemic that's been unleashed on Huntington.

Q. And you're saying that Huntington or Cabell has a claim to recover those funds instead of the federal government having a claim to recover those funds. Is that what you're saying?

A. No, I'm not making that distinction, because that's a legal conclusion that needs to be determined by -- by you attorneys and the trier of fact. I'm simply calculating what the cost of the fares based upon the number of trips that are being specified in Doctor Alexander's redress model.

Q. But now if the figures that you're showing on this tab for Bus Fares, those are not -- you don't re -- those aren't reduced based on the reception of federal assistance; those are the full amounts before any deduction, if it's warranted, for the amount received from the federal government. Right?

A. Are you speaking specifically about the individual $1.00 fares or the total amount of money included in my calculation?

Q. I assume the $1.00 fares are -- well, you tell me. Are the $1.00 fares some notional effort on your part to determine the cost of transporting people, or is this actually, you're going to -- you

that type of a calculation to test the 7,882 assumption that Doctor Alexander uses?

A. No. I find it -- it would be incredibly inappropriate for me to go behind Doctor Alexander and make that kind of calculation, because that's his area of expertise, not mine. I'm just simply not qualified to do that. I'm an economics expert; I'm not an epidemiologist.

Q. Well, now, if you had used for your calculations -- this is probably an obvious point, right? But if you had used for your calculations not a population of 3,152 people who were getting treatment, but a population of about 460 people who were getting treatment in Cabell/Huntington in that first year, your totals would be, you know, one sixth or so or one seventh or so of what are reflected in this tab. Correct?

A. I do agree with you that hypothetically, if there are less people receiving treatment, then the total costs will be less, yes.

Q. And just using the most simple math, if the population were 460 instead of 3,152, 460 is 15 percent of 3,152, then your dollar amounts on this page would be about 15 percent of what we see

instead. Correct?

A. Generally I would say that that may be true, but you have to remember that there are four different levels of treatment which have different costs associated with those levels, so it would be weighted a little bit differently --

Q. Yeah.

A. -- depending upon how many people show up in each of the categories.

Q. Yeah, and I totally recognize that it would be -- there would be some variation. I was just trying to give a real rough ballpark.

A. And I think what you did is a real rough ballpark. Yes, I agree with that.

Q. Now, do you know who currently pays for opioid use disorder treatment in Cabell/Huntington?

A. No, I do not.

Q. Do you know whether the County or City have ever paid even a dollar towards the treatment of people in their community with opioid use disorder?

A. No, I do not.

Q. Do you understand that many or most people with opioid use disorder are -- have their treatment paid for by Medicaid?

A. Which would be the federal government?

Q. Be a combination of the Federal and the State government. Do you know whether or not that's true that most people with opioid use disorder in Cabell/Huntington, their treatment is paid for by Medicaid?

A. Well, given the income level of the local area and Medicaid being a federal transfer payment program, essentially welfare, that makes sense, yes.

Q. And -- just transitioning to a real world -- and what does this mean in a real world, if there were an -- if Doctor Alexander's abatement program were put in place, do you -- is it your understanding that Cabell/Huntington would begin to run a public health system by which they themselves would treat everyone with opioid use disorder in their community rather than letting hospitals paid for by Medicaid handle that?

MR. BURNETT: Objection.

A. I don't have an opinion on that. I simply valued the cost based upon the number of individuals identified by Doctor Alexander and the costs associated with those treatment sources.

Q. And you are agnostic as to who was actually going to pay that cost in the future; is that right?

A. Yes, throughout the course of my work in this case, who has paid for and who is going to pay for is not my opinion. I don't have any conclusions or any say on that. These are simply the dollars that are necessary to pay for the things that have been identified by Doctor Alexander.

Q. Okay. Now, if you go to the Medications tab, which is the next tab -- it's still 2B, but it's 2B5, 6 and 7.

A. Yes.

Q. What does that reflect? Does that reflect the cost of the treatment drugs used for the people who are getting treated with OUD?

A. It's my understanding, yes, these are the medications that would be prescribed as part of the treatment protocols for individuals with opioid use disorder.

Q. Okay. And similar to the treatment itself, you know, the cost of treatment, you don't know who has paid in the past or who will pay in the future

for these drugs; is that right, these treatment drugs?

A. Yes, that is correct.

Q. Okay. And if we go to Tab 2C, which are complications, are these the costs of screening for and treating for Hep C and HIV?

A. Yes, in Tab 2C1, these are the costs for diagnostic screening of individuals for Hepatitis C and HIV.

Q. And 2C2 is the cost of treating people with Hep C, correct?

A. Yes, that is correct.

Q. And 2C3 is for treating people with HIV, correct?

A. Yes, that is correct.

Q. Do you know whether the numbers of individuals reflected on this page are people who -- like in the HCV treatment, the 446 number --

A. Uh-huh.

Q. -- and for HIV treatment, the 25 number, do you know whether any effort was made to determine whether those are individuals or -- whose Hep C or HIV post-dated and derived from an opioid use disorder or whether, in reverse, they had HIV or

Q. Well, the document you're referring to is an e-mail from Sean Bowles to Dan Underwood, correct?

A. Yes, that is correct.

Q. And in that e-mail, Mr. Bowles tells Mr. Underwood at the bottom, "Please remember the TRC was employed by Prestera and assigned to us." Do you see that?

A. Yes, that is correct.

Q. And so is it your understanding as well that in the past, the triage and referral coordinator used in the LEAD program was not employed by the County or the City but was employed by an independent organization, Prestera, and was assigned to the County or City. Correct?

A. That -- according to this document, that would be correct, yes. But for purposes of my calculations, again, who pays for it and who they work for is largely irrelevant because this is the cost of that program.

Q. But at least for this program, that cost was originally incurred and paid for by Prestera, maybe underwritten by some grant. Is that right?

A. I'm not so sure about that. According to

this document, it just basically states that the individual was an employee of Prestera. So they're getting their paychecks from Prestera. Who pays for that funding - is it transferred, is it a grant, is it reimbursed - I don't know. This document doesn't signify that.

Q. Now, why is your firm's letterhead -- or legend stamped on the bottom of this page?

A. It just so happened to be the paper that was in the printer whenever I printed this. My apologies for that.

Q. That's fine. I assumed there was some innocuous explanation. I was just curious of what it was. Or maybe that you stamped all documents that you received with that stamp.

A. No, no, not at all, it's just that was the doc -- the paper that was in the printer at the time.

Q. I've done that before, and it annoys me because the letter stock is more expensive than the regular paper.

A. Me too.

Q. Yeah. So again, just -- we sort of just touched on this a second ago, but in terms of your

calculation of the -- that $80,000 cost for the two triage and referral coordinators, you're agnostic as to who's actually going to pay for that in the future. Correct?

A. That is correct.

Q. Okay. And I think I asked this earlier about the LEAD program. Are you aware or not aware of the fact that LEAD programs across the United States are funded in whole or in part by the federal government?

A. I can't recall specifically who provides the funding for those types of programs. But for purposes of my calculations, again, it doesn't matter.

Q. And I note -- you also don't have this category for Specialized Overdose Units. These are -- you used detective salaries for those, so you're assuming two detectives will be assigned full-time to a specialized overdose unit; is that right?

A. That's right. Previously when we looked at the redress model by Doctor Alexander and how it identified law enforcement, first responders generally from their occupations, average wage data was sufficient for making the estimate.

But here, in this specific category, Doctor Alexander recommends that the cost be based upon a detective's full-time equivalent annual compensation.

Q. And those individuals would be responding to overdose calls; is that right?

A. I am not certain as to what the job responsibilities of those individuals would be. For the scope of my work, I don't really need to understand that because Doctor Alexander has told me specifically that it should be valued at the median annual detective's salary and that there are two needed.

Q. Well, in -- was it you or Doctor Alexander who gave them the name Specialized Overdose Units?

A. I did not give them that name. I didn't identify or give any of these categories names.

Q. Doctor Alexander is -- gave you that name?

A. If you took at Tab 3A in the Appendix to Doctor Alexander's report, under Row 3, he identifies this to be the Specialized Overdose Unit.

Q. Okay. Well -- and maybe this is something you don't know about, but let me just try -- I

Toddlers, Developmental Services.

And as part of that, there is an identified cost that Doctor Young provides at $1,300 per intervention, and because this is provided in Doctor Young's report, I would assume that it's a 2020 value. And that's a conservative assumption, because I'm not going to increase that value from prior years up to 2020. I'm just going to assume that it's already in 2020 dollars.

So I'm going to increase that into the future by 2.5 percent, which is the Services by Other Medical Professionals rate of increase, and so when you look at that column -- or that row of data starting with $1,333, which is the early intervention cost estimate provided by Doctor Young, we'll increase those figures by 2.5 percent, moving from left to right, year by year.

When you get out to Year 2035, you'll see that the price increase has gone up to $1,883.

Now, if you're looking at the same version that I am, which is the errata version, the number of individuals is a little bit different than was in the first August -- the initial August 3rd report, and so the estimated costs are all a

little bit different for each year from what they were previously. But those should be identified in red for you.

Q. Sorry, bear with me one second here. In terms of these IDEA assessments and these individualized family service plans, do you understand who historically has funded the provision of those assessments and reviews?

A. Typically the county boards of education would have been responsible for that, with funding through the State government and supplemented by the Federal government.

Q. And jumping down to the special education services referenced in 4A4c, are those likewise typically provided by -- well, who typically provides and pays for special education in West Virginia?

A. The state of West Virginia, again, supplemented by the Federal government and the county school system as well. There are three levels of funding which take place.

Q. And the figures reflected here in your report for special education services, that reflects the full cost. It doesn't seek to

allocate as between which portion is funded by the Federal government, which by the State government and which by the County government; is that right?

A. That's right. Just as we've been talking about, all the other previous categories, I'm not looking at a particular funding source; I'm simply calculating how much the future values are going to be for each one of these categories.

Q. Okay, let's go to 4B, which is Adolescents and Young Adults.

A. Okay.

Q. The first item that you price out are School-Based Prevention Programs, correct?

A. Yes.

Q. And are you aware of any school-based prevention programs currently in place in the Cabell/Huntington community?

A. No, I've not reviewed any, no.

Q. Okay. Do you know whether there's any life skills training programs in place in the Cabell/Huntington community?

A. Life skills training as a component of special education services? I have not looked at Cabell County's curriculum. It should be a

Oop. Now we're getting the dog.

MR. HALLER: Without the echo.

MR. BURNETT: We've got a Jim Peterson and a Jim. I don't know that that matters. I'm just pointing it out. Two separate dials in.

Q. And similarly here -- you -- what you know about the services is only what's reflected in the Young report; is that right?

A. Yes, that is correct.

Q. Okay. And the $2,332 figure, is that related to her $2,018 cost estimate?

A. That is representative of what she identifies to be the intensive --

Q. Right.

A. -- parent child intervention cost per family, and she makes a distinction for this particular category that in addition to those intensive parent/child interventions, that there's going to be peer family mentoring services, and it's that peer family mentoring cost that she has reduced the cost from $30,000 to $12,500.

Q. Right. And she references the START program in connection with that previously $30,000 and now $12,000 amount. Correct?

A. Yes, that is my understanding.

Q. And do you know where the funding currently comes from for the START programs throughout the U.S.?

A. No, I do not.

Q. Okay. And is that -- if it's the federal government that funds the START programs, I take it you have not made any attempt to reduce the dollar amounts of your figures by the amount of Federal funding. Again you are agnostic as to where the funding is coming for for these programs, right -- coming from for these programs, right?

A. Yes, that is correct. I'm indifferent as to the funding source. These are simply representative of what the future value costs will be.

Q. The next category, Support for Children in Foster Care, do you know how the number of children in foster care due to parental opioid use is derived?

A. Doctor Alexander identifies that number on page 4C in Row 6 under the Subcategory, Support for Children in Foster Care. The number starts off at 239 children and then changes from year to year. I

believe that it actually decreases every year until 2035.

Q. And in West Virginia, who pays for foster care services, the County or the State?

A. The State Department of Health and Human Resources makes a reimbursement payment to families based upon a minimal monthly amount. But the actual payments will be dependent upon the individual families that are paying for the foster children in their care.

Q. And again, I know this is repetitive, and I appreciate your patience. But the -- even though the State is paying for foster care services in West Virginia, not the County, that doesn't affect your numbers because you're agnostic as to who's paying these amounts; is that right?

A. That is correct, yes.

Q. Now, the next tab -- I have a 4C tab that's all in red. That's 4C2d --

A. Yes.

Q. And can you describe what you're pricing on that page?

A. Yes, I can. When Doctor Young's first report was submitted, she did not include any

information which would allow me to calculate what the future values would be for this category of Intensive Parent-Child Interventions & Family Treatment Court for Foster Families.

And it was the Family Treatment Court which was a new item -- it's not a Drug Court, it's something that's unique for children and families. And I needed to have that information, and it wasn't provided to me until very, very, very late on the last day that the production of the calculations were being done.

So I wasn't able to include that information into the initial report. So my errata includes the inclusion of this category of costs which did not appear in my first report.

Q. And what is your understanding of what a family treatment court for foster families is and what it does?

A. I don't have very much understanding at all about this. This is a somewhat new concept for me, even within the practice of vocational rehabilitation. I don't have much of an understanding of this one.

Q. And do you have any vague understanding, or

utilized historical data for what the plaintiff had expended on themselves for their own medical care prior to the award of a lump sum settlement or any type of judgment, the quality and quantity of the care is going to be adversely affected by the lack of funds which could be assumed because of the injury.

So if you have a person who's not working and therefore has no income stream, you would not want to use what they historically had paid for their own health care treatment or even household services replacement costs based upon the money that they didn't have to spend on the adequate replacement of those services and treatment items.

The same would be true here. And I've alluded to that several times today as we've been talking. You can't assume that the money that has either been spent or has not been spent is relevant to the particular redress model because the financial resources of Huntington are limited in to what they could actually pay for.

So I believe that that would adversely affect any type of a projection that you would be

made.

Q. Okay. Do you have any view as to whether, in your expert work, if you're relying on the work of another expert that you do due diligence on the work of that other expert?

A. Absolutely not. I have no qualifications to verify the conclusions of an expert in another field of expertise, so no, I would find it very inappropriate to make any distinctions as to the qualifications of an expert in another field or the quality of the work that they performed in another field of expertise.

Q. Have you ever written in a newsletter the following - and I'll quote it - quote, "Another suggestion, especially when two experts have not previously worked together," if a telephone call -- "is that a telephone call between the two occur before either issues a report. Rather than being a sinister activity, we view this as an important due diligence when one expert is the foundation for the other."

A. Sure, absolutely, I recall that.

Q. And so in that statement, you seem to be suggesting that due diligence on the work of

another expert that you're relying on is an important part of your process when that other expert's work is a foundation for your own. And can you explain to me why that can be generally true but not true in this instance?

A. Absolutely. When we speak about due diligence in that newsletter, as that relates to having a conversation with a related expert, what I am referring to is understanding what that expert is giving me in their opinion. Understanding that information is important.

The due diligence is not me questioning the abilities or the opinions or the accuracy or the validity of the opinions of what that expert is saying. It's necessary so that I'll understand what that expert is talking about.

And that's exactly what transpired in this case from the very beginning of my work in early spring in having routine, regular telephone conversations with Doctor Alexander and Doctor Alexander's staff so that I would understand the information that was being presented to me.

That is the necessary due diligence. It's not a matter of me questioning the integrity,